the public's preferred goal of a worthwhile life with good health. Subtle indoctrination, which encourages a shift away from the conduct of a professional who is meant to tend the ill to a man whom the economists counsel to tend the cash register for society, should be viewed with concern.

Practitioners should, of course, be accountable where waste and inefficiency surface. The move from the hospital back to the office for appropriate diagnostic and surgical procedures is part of such accountability (despite the increased malpractice liability). Furthermore, the move away from the costly emergency rooms exposes the economic and medical fallacies of the mandatory specifications from the Hill-Burton bureaucracy for such service.

The recent emphasis on the cost-benefit relationship derives from the bureaucratic concept of medical care as an industry or business. Few will deny that the legislative component of the government has been and so far continues to be a significant part of the problem of the high cost of patient care. The thought occurs that a rudimentary political medicine is being worked out from heretofore ruinous political economics, oblivious of the conflict between price and medical efficacy.

The economists' inroads into patient care are justified on the grounds that there is a similarity in market procedures to medical care and commercialism. There is, of course, a limited role for the market in medical care—for example, supplies, food, laundry, armamentaria, maintenance and nonprofessional labor. No activity, commercial or professional, can subsist without some such requirements. The elemental fact, however, remains that the material, the product and the result are not comparable.

Competition, currently being promoted as the key to cost containment of medical care (as noted in the editorial "Competition in the Health Care Enterprise"[1] in August), is of two kinds: (1) *professional,* involving skill and competence, and (2) *price,* widely popularized by Professor A. C. Enthoven, whose discipline (economics) by its very nature is relevant to the commodities market but not to patient care. Our deepest concern that it is unprofessional to compete in price, long held as the foundation of all professionalism, was singled out for legal disapproval by judges unsure of its meaning and justification. (Witness the admission in a footnote to a 1975 Supreme Court decision that "professional practice was different from other [sic] business activity."[2])

Price competition is germane to commercial ventures, not professional conduct. There is a proper place for pluralistic medical care approaches to satisfy various tastes and needs. However, when the burden of participating in such ventures (with pressures exerted for cost containment) is placed upon the medical profession, there is some ground for the conclusion that it constitutes an inroad of commercialism into professionalism with what I believe to be a further deprofessionalization of the profession.

Underneath all the jargon of competition, the old truism "you get what you pay for" seems forgotten. Implied in it lies conservation—reducing the consumption of medical care to contain its cost. But what you end up with is cost-shifting; from the government, insurer and employer to the patient. The theory presupposes that if you are to pay for something from your own pocket you will shop or forego the service. That is true for commercialism, but when it comes to life and health, the human odds in most cases are against such a supposition. Note the testimony of "shoppers" from prepaid group plans. Cost reduction can be made to look good on paper, but when all the costs are added up, you will still come up with virtually the same figures for cost of medical care.

There is a direct correlation between cost and scientific and technological achievements; hence, the expectation of a solution to the high cost through competition remains to be seen. Such expectation is further in doubt through the paradoxical suggestion of controls on quality and accessibility—a costly governmental regulation that runs counter to the mood of the country in last year's election.

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1. Competition in the health care enterprise (Editorial). West J Med 135:135-136, Aug 1981
2. Costillo LB: Competition policy and the medical profession (Sounding Board). N Engl J Med 304:1099-1102, Apr 30, 1981

Chinese Medicine

TO THE EDITOR: Eloquent truths are so often unconsciously spoken. This was brought home to a group of us on a recent trip to China during which we were given the opportunity to observe how Chinese medicine is practiced in their hospitals. As we passed from room to room we saw patients undergoing various forms of treatment. Some were subjected to cupping, others had warm paraffin packs on their abdomens for the treatment of

ulcers. There were rooms devoted to ultraviolet and infrared therapy. And, of course, we saw patients with needles in their ankles, wrists and earlobes, perhaps with a ginger root smouldering on the thenar eminence of the right hand.

Everywhere there was total compliance, especially in the patients undergoing acupuncture. Not a muscle moved, not an eyelid blinked, and there was never so much as a furtive glance at this troop of foreign doctors. The attending physician assured us that their treatments were highly successful. We recalled the consensus report of the President's Committee on Acupuncture. The conclusion was "Acupuncture works, in China, on the Chinese."

We progressed down the hall to the pharmacy where we were shown various materials used in the preparation of their "natural remedies." Not only do they use flowers, bark, roots and herbs, but also dried frogs, sea horses, snake skin and shark fin. These are pulverized into potions to be administered for specifically indicated diseases and disorders.

As always, at the end of such hospital tours, there was a friendly question-and-answer interchange over the traditional tea cups. It was here that two truths unfolded.

One physician, after observing patients throughout the hospital puffing away at those fat Chinese cigarettes, asked why this was permitted. The answer through the interpreter was, "The Government *persuades* but does not *prohibit*. Also, the Government owns the tobacco factories."

Truth Number One.

Another question: "We have seen various applications of Chinese medicine this morning. Do you ever use Western medicine?" The answer: "In the occasional acute case where more rapid cure is needed, yes, we will use Western medicine."

Eloquent truth Number Two. Anyhow, in America, on Americans, Western medicine works.

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Corrections: October Article by Bruce, Hossack, Belanger, et al

TO THE EDITOR: In our article "A Computer Terminal Program to Evaluate Cardiovascular Functional Limits and Estimate Coronary Event Risks"[1] in the October issue, a manuscript error resulted in incorrect regression equations on page 343.

The corrected equations should be as follows:

$\dot{V}o_2$ max = 0.056 (duration in seconds) + 3.88 for men;

$\dot{V}o_2$ max = 0.056 (duration in seconds) + 1.06 for women.

In other words the decimal point was misplaced for 0.056 and the figure was printed as 0.56. The intercept coefficient 3.99 should have been 3.88 and the sex identity for the two equations was omitted.

A second error, this one apparently a mistake by the journal's printer, was the omission of two words and a heading in Figure 2 on page 344. Under item 14, "Evidence for Heart Disease," it lists "1. Inapparent" and "2. Possible." Two other classifications—"3. Probable" and "4. Definite"—should have been included. The following section should have been headed "15. Cardiovascular Diagnosis."

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REFERENCE

1. Bruce RA, Hossack KF, Belanger L, et al: A computer terminal program to evaluate cardiovascular functional limits and estimate coronary event risks (Health Care Delivery). West J Med 135:342-350, Oct 1981

Further Correction: Formula to Calculate Serum Osmolality

TO THE EDITOR: This is just a quick note in between patients to inform you that your magazine "blew it again." I am referring to the correction for the formula to calculate serum osmolality.[1,2] In order to be correct, the number under BUN should have been 2.8 and not 28, thus the formula should read as follows:

$$2 \times \text{Na} + \frac{\text{BS}}{18} + \frac{\text{BUN}}{2.8} = \text{osmolality}.$$

Actually many clinicians use 3 instead of 2.8 because it is easier to calculate without the fraction and the result is close enough to be of practical value.

Don't despair. The journal is usually on the mark.

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EDITORS' NOTE: The normal range for serum osmolality, calculated as above, is 285 ± 4.2 mOsm per kg H_2O.

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1. Becker CE: Acute methanol poisoning—'The blind drunk'—Medical Staff Conference, University of California, San Francisco. West J Med 135:122-128, Aug 1981
2. Correction: Formula to calculate serum osmolality (Correspondence). West J Med 135:341, Oct 1981